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No. 88-2043

In The

Supreme Court Of The United States

OCTOBER TERM, 1988

GERALD L. BALILES, ET AL.,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

BRIEF AMICI CURIAE OF THE STATES OF CONNECTICUT, ALABAMA, ALASKA, ARIZONA, CALIFORNIA, COLORADO, DELAWARE, FLORIDA, GEORGIA, HAWAII, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, KENTUCKY, LOUISIANA, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEVADA, NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA and WYOMING IN SUPPORT OF THE PETITIONER COMMONWEALTH OF VIRGINIA

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INTRODUCTION

The States of Connecticut, Alabama, Alaska, Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia and Wyoming (hereinafter the "Amici States") submit this brief in support of the Petitioner Commonwealth of Virginia. The decision of the Fourth Circuit in *Baliles v. Virginia Hospital Association*, 868 F.2d 653 (4th Cir. 1989), should be reversed.

QUESTION PRESENTED

Whether the Medicaid statutes give health care providers (i.e., hospitals and nursing homes) a private right of action enforceable through 42 U.S.C. § 1983 (1982) to challenge state reimbursement decisions in federal court.

INTEREST OF AMICI CURIAE

The State of Connecticut et al. submit this brief as amici curiae in support of the petitioner in this case, Commonwealth of Virginia. Virginia seeks reversal of the decision of the United States Court of Appeals for the Fourth Circuit in *Virginia Hospital Association v. Baliles*, 868 F.2d 653 (4th Cir. 1989). In urging the Court to reverse the decision of the circuit below, the State of Connecticut is joined by 45 additional states.[1] The amici states, individually and collectively, have an overriding interest in the question presented in this case: whether health care service providers have a right enforceable through section 1983 to sue in federal court for a particular level of Medicaid reimbursement.

This case presents the same issue on which this Court granted certiorari in *Coos Bay Care Center v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), *cert. granted*, 481 U.S. 1036, *judgment vacated and remanded on issue of mootness*, 484 U.S. 806 (1987) (Coos Bay): Did Congress intend to permit providers of health care services under 42 U.S.C.§ 1396a(a)(13)(A) (1986) to bring suit against the states under 42 U.S.C. § 1983 (1982) when it amended the Medicaid statutes in 1980? The issue is no less important today than it was in 1987 when a majority of the states, several organizations representing local governments, and the United States Solicitor General all joined Oregon in requesting this Court to reverse the decision of the Ninth Circuit Court of Appeals allowing providers to sue. Indeed, the rapid growth of litigation in the area and the enormous amounts of money at stake bear stark witness to the Court's prudence in agreeing to hear that case and the ever-increasing importance to the States of the decision in this case.

[1] This brief of amici curiae is filed pursuant to Rule 36.4 of the Rules of the Supreme Court. Amicus State of Arizona does not participate in the Medicaid program directly. However, it participates in a cooperative state-federal program under a special grant that provides funds for indigent health care. Because of the similarities between this special grant program and the Medicaid program, Arizona has an interest in the issues presented in this case.

The number of challenges to state reimbursement systems by providers of inpatient hospital and long-term care services to Medicaid recipients has been substantial in recent years.[2] Each of these challenges has the potential to involve very large amounts of money drawn from both state and federal treasuries.[3] Because the total number of state and federal dollars paid annually through medical assistance programs is truly staggering, the burgeoning number of cases has the potential to subject federal and state governments to liability running easily into the hundreds of millions of dollars.[4]

Medicaid is a voluntary, cooperative federal-state program that provides funds to reimburse certain costs of medical treatment for the needy. Each of the amici states participates in the Medicaid program, except Arizona. See footnote 1. As required by federal law, a participating state's Medicaid program must fund institutional medical care, including care in inpatient hospitals, nursing facilities, and intermediate care facilities (collectively referred to as "providers"). The amount

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[2] See Appendix A for a representative sample of section 1983 challenges to Medicaid reimbursement rates which was appended to the brief of thirty-seven states as amici curiae concerning the Petition for Certiorari in this case.

[3] For example, *Volk, et al. v. Oregon, et al.*, cited in Appendix A, although involving only one year's reimbursement schedule and involving the nursing home industry but not hospitals, has over $5 million at stake, more than $3 million of which is federal money. The several Pennsylvania cases may entail liability of $80 million.

[4] As the United States Solicitor General noted in his brief in support of the State of Oregon in *Coos Bay*, the federal contribution to the Medicaid program for medical assistance totalled $23.4 billion in 1986. Brief For The United States As Amicus Curiae Supporting Petitioners, at 2, citing HEALTH CARE FINANCING ADMIN., DEP'T OF HEALTH AND HUMAN SERVICES, MEDICAID FINANCIAL REPORT: FISCAL YEAR 1986. Federal funds comprised at least 50 and in some cases more than 70 percent of each state's medical assistance program in 1986. 49 Fed. Reg. 46,957 (1984). The average figure was approximately 58 percent. Thus, treating 1986 as a representative year, and including the states' contribution, the total medical assistance budget is over $40 billion per year.

of federal-state dollars directed to needy persons through private, for-profit providers is a major portion of the overall Medicaid program.

The amici states have a substantial financial stake in the outcome of this case and a significant legal interest in its resolution. The decision below holds that a health care provider may bring an action under section 1983 to challenge the provider reimbursement rate set by a state and approved by the federal government. Providers are thus free to attack, on a year-by-year and provider-by-provider basis, the "reasonableness" of each state's reimbursement rates. Every routine rate challenge may be made a federal case.

Many of the amici states already are caught up in the explosion of provider litigation based on alleged federal rights to specific levels of reimbursement. Indeed, some amici states are under siege by multiple lawsuits for different years, different classes of providers and inconsistent claims as to the rate allegedly guaranteed by federal law. Millions of state and federal dollars are potentially at stake in each lawsuit. Collectively, hundreds of millions of dollars are involved. The amici states therefore file this brief and urge the Court to reverse the decision of the circuit below.

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SUMMARY OF ARGUMENT

It is settled law that health care providers are not the intended beneficiaries of the Medicaid Act. Further, the better reasoned caselaw extends this settled principle of law to its next logical step, *to wit*, because providers are not the intended beneficiaries of the Medicaid Act, providers lack standing to sue state Medicaid agencies in § 1983 actions over alleged violations of said act.

In addition to lacking standing, Congressional intent, as revealed by the language and history of the 1980 amendments to the Medicaid statutes, refutes the circuit court's conclusion that the Medicaid statutes give providers a legally enforceable right to sue states over reimbursement rates under the aegis of section 1983. The Boren Amendment to 42 U.S.C. § 1396(a)(13)(A) provides only that states must provide "assurances" to the Secretary of Health and Human Services that rates are reasonable and adequate. There is no language in the amended statute suggesting enforceable rights. The history of the amendments confirms that Congress intended to decrease federal oversight of state rate-making. Layering federal judicial scrutiny on top of administrative and state court judicial review runs directly counter to that intent. Rather than reducing federal oversight of the state rate-making process and entrusting the states with primary responsibility for those rates, as Congress intended, the result below increases federal oversight and transfers primary rate-setting authority to the courts by means of § 1983 actions.

ARGUMENT

I. HEALTH CARE PROVIDERS ARE *NOT* THE INTENDED BENEFICIARIES OF THE SOCIAL SECURITY ACT.

The *amici* states respectfully submit that the point of departure for appropriate analysis of the question presented is the settled principle of law that the intended beneficiaries of the Social Security Act are the recipients of benefits and *not* health care providers. *Silver v. Baggiano*, 804 F.2d 1211, 1216–1217 (11th Cir. 1986); *Oberlander v. Perales*, 740 F.2d 116, 121 (2nd Cir. 1984); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir. 1981) (nursing home provider "is not the intended beneficiary of Medicaid program."); *Dialysis Centers, Ltd. v. Schweiker*, 657 F.2d 135, 139 (7th Cir. 1981) ("the statute manifests no Congressional intent to protect the financial interests of health care providers"); *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1242 (7th Cir. 1981) ("The provider . . . is *not* the intended beneficiary of the Medicare program." (emphasis in original)); *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979) ("We do not find in the statute authorizing Medicare and Medicaid any legislative intention to provide financial assistance to providers of care for their own benefit. Rather, the statute is designed to aid the patients and clients of such facilities."); *Cervoni v. Secretary of H.E.W.*, 581 F.2d 1010, 1018 (1st Cir. 1978) (physicians not intended beneficiaries under Medicare Program); *Case v. Weinberger*, 523 F.2d 602, 607 (2nd Cir. 1975) ("A nursing facility's 'need' for patients has nothing to do with the statutory benefits structure. . . . The benefits to a nursing home from its participation in Medicaid reimbursement result from nothing more than a statutory business relationship."); *St. Joseph Hospital v. Electronic Data Systems*, 573 F.Supp. 443, 447 (S.D. Texas 1983) (case law "clearly establishes that providers are not the intended beneficiaries of the Medicaid Program."); *Thomas v. Johnston*, 557 F.Supp. 879, 903 (W.D. Texas 1983) ("[I]t is abundantly clear that it is

Medicaid recipients and not Medicaid providers who are the intended beneficiaries of the Medicaid program."); *In Re Park Nursing Center, Inc.*, 28 B.R. 793, 805 (Bankr. E.D. Mich., S.D. 1983).

To the contrary, health care providers are business entities that made the voluntary business decision to enter the Medicare or Medicaid Program. *St. Francis Hospital Center v. Heckler*, 714 F.2d 872, 875 (7th Cir. 1983), *cert. denied* 465 U.S.1022 (1984) (Medicare); *Middletown Haven, Inc. v. Maher*, C.C.H. MEDICARE & MEDICAID GUIDE ¶34,249 (Conn. Super. Ct. 1984) (Medicaid).

It is self-evident that health care providers are no more the intended beneficiaries of the Medicaid Program than construction companies are the intended beneficiaries of government appropriations to build elementary schools. Rather, both are businesses participating in government programs designed to assist those in need.[5] If a health care provider is dissatisfied with his future anticipated rate levels, his remedy is to not renew his contract (provider agreement) with the government and to leave the Medicaid Program. *Minnesota Assoc. of Health Care Facilities v. Minnesota Dept. of Public Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985), (providers are free to decline to participate in the Medicaid Program if they are dissatisfied with a state's rates).

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[5] Indeed, the law of the Second Circuit is that providers have no property interest in prospective reimbursement rates. *Oberlander v. Perales*, 740 F.2d at 120; *Grossman v. Axelrod*, 646 F.2d 768, 771 (2nd Cir. 1981). See also *Murthy v. Perales*, 1989 WL 19136, C.C.H. MEDICARE & MEDICAID GUIDE ¶37,818 (S.D.N.Y. 1989) ("the contractual nature of the relationship between a Medicaid provider and the State . . . indicate[s] that the provider's interest does *not* rise to the level of a constitutionally protected property interest." (Citing *Plaza Health Laboratories v. Perales*, No. 88-8939 (S.D.N.Y. 1989), *aff'd* 878 F.2d 577 (2d Cir. 1984) (emphasis in original)).

II. BECAUSE PROVIDERS ARE NOT THE INTENDED BENEFICIARIES OF THE MEDICAID ACT, PROVIDERS LACK STANDING TO SUE STATE MEDICAID AGENCIES IN § 1983 ACTIONS OVER ALLEGED VIOLATIONS OF SAID ACT.[6]

As demonstrated *infra*, it is undisputed that the express wording of 42 U.S.C. § 1396a(a)(13)(A) does *not* contain a specific grant of a private right of action and merely sets forth certain obligations of the state Medicaid agency to the Secretary of Health and Human Services for approval of state Medicaid plans. Indeed the only part of federal Medicaid law that addresses provider challenges to their Medicaid rates is 42 C.F.R. § 447.253, the federal regulation mandating that state Medicaid agencies establish an administrative appeals procedure for providers to contest Medicaid rate decisions.[7] As state uniform administrative procedure acts generally afford judicial review of the record of agency final decisions, this results in state court judicial review as well.

As we turn to the issue of whether a third party, non-intended beneficiary provider possesses by implication an enforceable right under 42 U.S.C. § 1396a(a)(13)(A), the appropriate point of departure is *Cort v. Ash*, 422 U.S. 66, 78 (1975), which held that, in determining whether a private remedy is

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[6] As will be demonstrated herein, being an intended beneficiary is necessary to have enforceable rights in a statute. However, even when one is an intended beneficiary (which in this case providers are not), such status in and of itself does not establish enforceable rights. See *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

[7] This evinces federal intent that provider challenges to Medicaid rates be confined to state administrative hearings and subsequent state court judicial review and *not* be brought in the form of § 1983 actions. See *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 ("[w]here a statute expressly provides a particular remedy, a court must be chary of reading others into it."); *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 97 (1981) ("The presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement).

implicit in a statute not providing one, the first relevant factor is whether the plaintiff is "one of the class for whose *especial* benefit the statute was enacted . . ." (emphasis in original).[8]

Two circuits have recently invoked this *Cort v. Ash* analysis to reject attempts to imply private rights of action in other sections of the Social Security Act. *Wehunt v. Ledbetter*, 875 F.2d 1558, 1563–1566 (11th Cir. 1989) (re: Title IV-D of the Social Security Act, 42 U.S.C. §§ 651 *et seq.*); *West Allis Memorial Hosp., Inc. v. Bowen*, 852 F.2d 251, 255 (7th Cir. 1988) (re: 42 U.S.C. § 1395nn(b)(2)(B) of the Medicare fraud portion of the Social Security Act). Those cases are most significant because, like § 1396a(a)(13)(A) in this case, both cases involved sections of the Social Security Act in which it was the government and *not* private parties charged with enforcement responsibility. See 875 F.2d at 1565; 852 F.2d at 255. The *West Allis* case, involving health care providers and the Medicare program, is of particular interest. In that case it was held that:

> "[N]either . . . [the statute] nor its legislative history suggests that Congress intended to provide a private remedy to Medicare providers such as West Allis. . . . The Secretary is charged with the administration of the Medicare Program. . . . Where a statute is framed as a 'general prohibition or command to a federal agency,' as it is in the present case, a private right of action will seldom be implied [citations omitted] . . . it is the Government, and not private parties, which is charged with the enforcement of the Medicare program. . . ." 852 F.2d at 255.

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[8] As will be demonstrated herein, the failure of non-intended beneficiary health care providers to pass muster under the *Cort v. Ash* interest analysis with respect to § 1396a(a)(13)(A) deprives health care providers of standing. In addition, the issue of whether under § 1983 there is any secured right to enforce remains. Footnote 7 *supra*, Argument III *infra*, and the case of *Middlesex City Sewerage Auth. v. National Sea Clammers*, 453 U.S. 1 (1981), demonstrate that health care providers fail on the latter issue as well.

Turning to the question presented, substantial caselaw has evolved as to lack of provider standing to sue state Medicaid agencies in § 1983 actions over an alleged violation of § 1396a(a)(13)(A) due to lack of intended beneficiary status. *Vantage Healthcare v. Virginia Board of Medical Assistance Services*, 684 F.Supp. 1329, 1331-1332 (E.D. Va. 1988) ("A number of courts, drawing on the statutory language, have stated that the Medicaid Act was enacted for the express and special benefit of the individual recipients. Such courts have held that health care providers are not the intended beneficiaries of the Medicaid Act . . . [describing and rejecting case law permitting providers to bring such § 1983 actions on the basis of perceived "parallel interests" with Medicaid patients as] the extreme end of the spectrum."); *Al-Charles, Inc. v. Heintz*, 620 F.Supp. 327, 335 (D.Conn. 1985)

> ("To the extent that the plaintiff [nursing home] is alleging here that the Title XIX Medicaid program creates an entitlement program for providers of medical services, as distinguished from recipients of medical services, such a claim has no merit . . . . Finally, to the extent that the claim rests on the assertion that the plainatiff has some entitlement under the Medicaid program, is an intended beneficiary of the Medicaid program, or has some federally protectable property interest in reimbursement rates determined by the state under the Medicaid program, the claim is insupportable.");

Arden House, Inc. v. Heintz, 612 F.Supp. 81, 84 (D. Conn. 1985) ("the test of a proper § 1983 claim is whether the claimant can 'demonstrate that it has suffered an injury by the administration of a joint federal-state cooperative program and was *an intended beneficiary* of that program.' [citation omitted]. (emphasis in original) . . . . The defendants contend, and the Court finds, that under this analysis, Arden House is not an intended beneficiary of the Medicaid program."); *Almond Pharmacy, Inc. v. Mankowitz*, 587 F.Supp. 925, 927-928 (N.D. Ill., E.D. 1984) (provider's § 1983 action over Medicaid

payment dispute dismissed, with court distinguishing between welfare recipients' right to sue in federal court *as opposed to* health care providers who are not the intended beneficiaries of the Medicaid Act and whose claims of alleged violations of the State Plan are enforceable in the state court system); *Pennsylvania Pharmaceutical Ass'n v. Dept. of Public Welfare*, 542 F.Supp. 1349, 1355-1356 (W.D. Penn. 1982)

> ("Congress enacted Title XIX of the Social Security Act to provide health care for the poor and aged, not to subsidize or otherwise to benefit health care providers [citations omitted]. By design the Medicaid program is structured to provide needed medical services to the poor . . . . If a provider finds participation in the program unprofitable he should withdraw from the program [citations omitted] . . . . "[After finding a lack of standing in the providers' challenge to the sufficiency of Pennsylvania's reimbursement schedules, the District Court declared:] "The poor, not the health care providers, are the intended beneficiaries of the Medicaid Act . . . . Accordingly, we find that Congress did not vest the . . . [provider] plaintiffs with an interest to challenge a state's payment schedules on the ground that these payments are insufficient . . .");

State Dept. of Public Welfare v. Bair, 463 N.E. 2d 1388, 1390-91 (Ind. App. 1 Dist. 1984), (wherein the Indiana Court of Appeals held that providers lack standing to challenge the reimbursement system since the Medicaid program was for the benefit of recipients and not for the benefit of health care providers. The Indiana Court of Appeals declared:

> "[I]t is obvious that the purpose of the Medical Assistance program is to ensure qualified recipients receive needed medical care and prescription drugs. Any resulting benefit to the plaintiffs is merely incidental and bears no relationship to the purpose of the

> program. It is clear the legislation here in question is not intended to serve as a welfare program for pharmacists [citations omitted]. The plaintiffs, therefore, have no standing.");

See also *Association of Seat Lift Manufacturers v. Heckler*, 619 F.Supp. 1570, 1571 (W.D. Mo., W.D. 1985) (Medicare providers lack standing to sue Secretary because providers not within "zone of interest" contemplated by Congress in enacting Medicare Act. Medicare Act not intended to subsidize providers).

The *Amici* states respectfully submit that the cases in this section constitute sound law which recognizes reality. The Medicaid Act was enacted to provide health care to the indigent institutionalized elderly, who *are* the intended beneficiaries, and not to enrich health care providers, who are *not* the intended beneficiaries of the Medicaid Program.

Not only are the providers, who are not the intended beneficiaries of the Act, in this case attempting to do something to which they are not legally entitled, but the ironic and socially disastrous results that would ensue if they succeed would be a nationwide disruption of the Medicaid Program via a flood of § 1983 actions against state Medicaid agencies and the resultant slowdown if not diversion of the valuable, scarce taxpayer dollars set aside for the care of Title XIX Medicaid patients, the true intended beneficiaries of the Medicaid Program.

III. NEITHER THE LANGUAGE NOR THE HISTORY OF SECTION 1396 SUPPORTS FINDING THAT PROVIDERS HAVE RIGHTS ENFORCEABLE THROUGH SECTION 1983.

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in 42 U.S.C. § 1983 (1982)[9] must be read literally, so as to create under that section a private cause of action against state officials for violations of rights conferred by federal statutes. One year after *Thiboutot*, this Court "recognized two exceptions to the application of 1983 to statutory violations." *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981) *(Sea Clammers)*, citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) *(Pennhurst)*. The Court held that a section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; see also *Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 423–24 (1987) *(Roanoke)*. Clearly, Congress did not intend to grant enforceable rights to providers of health care services when it amended the Medicaid statutes in 1980.

In *Pennhurst* the Court concluded that whether Congress intended to create rights enforceable under the aegis of section 1983 must be determined from the language and history of the act if the act does not expressly provide for such actions. In this case, the language is not the right- or duty-creating

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[9] 42 U.S.C. § 1983 (1982) provides, in pertinent part:

> Every person who, under color of any statute, ordinance, regulations, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

language a court must find to support a claim of rights enforceable under section 1983. In addition, the legislative history demonstrates that Congress intended to increase state autonomy and decrease federal oversight in the Medicaid reimbursement rate-setting process.

A. The language of section 1396 is not rights-creating language.

The act under consideration in *Pennhurst* referred to "rights" accorded to the intended beneficiaries of the act and "obligations" on the part of the states. Despite that language, this Court concluded Congress had not intended to create enforceable rights against the states. Rather, the Court determined, the language in question was merely precatory, a "nudge" in Congress' preferred direction. *Pennhurst*, 451 U.S. at 19.

The language of section 1396a(a)(13)(A) is far less likely to be employed by a Congress desirous of creating enforceable rights than is the language at issue in *Pennhurst*. Section 1396a(a)(13)(A) does not contain a specific grant of a private right of action. See *Wehunt*, 875 F.2d 1558 (11th Cir. 1989) and *West Allis*, 852 F.2d 251 (7th Cir. 1988), analyzing similar such sections of the Social Security Act. Nor does it read like a statute designed to "dictate specifically what the relevant government officials may and may not do." *Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987). Far from containing "right- or duty-creating language," *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979), section 1396a(a)(13)(A) permits participating states to devise reimbursement rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. . . ." The statute also provides that these rates are to be set "in accordance with methods and standards developed by the State." By its terms, therefore, section 1396a(a)(13)(A) vests rate-making discretion

in the state, subject to the condition that it makes "assurances satisfactory to the Secretary." As the *Pennhurst* Court noted in the context of the statute at issue in that case, "[i]t is at least an open question whether an individual's interest in having a State provide . . . 'assurances' [to the Secretary] is a 'right secured' by the laws of the United States within the meaning of § 1983." 451 U.S. at 28. Indeed, if the statutory requirement of assurances by the states confers any right on providers, it is only the right to have those assurances provided to the Secretary. The provision of the assurances then engages the machinery of the Secretary's review. The Secretary examines the assurances, the rates and the supporting data to determine whether the rates meet the statutory standard. The providers' "right," if any, is the right to have the Secretary perform his or her duty and conduct the required review to ensure proper accountability, not the "right" to substitute themselves and the courts for the state, under the scrutiny of the Secretary, as rate-maker.

Thus, in *Pennhurst*, this Court did not find enforceable rights despite language of right and obligation. Here, by contrast, the court of appeals found enforceable rights despite the lack of right- or duty-creating language. This Fourth Circuit holding flies in the face of the limited language of "assurances" this Court has previously found questionable as the basis of "enforceable rights."

The lower court acknowledged that the statute at issue in this case, like the statute in *Pennhurst*, was enacted under the spending power of Article I, section 8, clause 1, of the United States Constitution. 868 F.2d at 657, n.3. *Pennhurst*'s insistence on clear legislative direction in spending power cases stemmed from the Court's concern that states be informed of their obligations in unambiguous terms when they enter into a voluntary, federally supported program.

> [L]egislation enacted pursuant to the spending power is much in the nature of a contract. . . . The legitimacy of Congress' power to legislate under the

> spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the "contract". . . . There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it.

451 U.S. at 17 (citations omitted). The lower court believed this concern is "allay[ed]" in this case because the states undoubtedly knew they were agreeing to pay reasonable and adequate rates when they elected to participate in the program. 868 F.2d at 659. It is one thing to say the states knowingly bound themselves to pay reasonable and adequate rates under the supervision and control of the Secretary. However, it is quite another to say they knowingly agreed to defend expensive, time-consuming and disruptive litigation in state and federal courts brought by each disgruntled provider over every aspect of and change in their programs. To make a simple analogy, even a consumer who felt she had no real choice but to enter into a particular contract is entitled to know it has an attorney fees provision in it.

Providers are voluntary participants in the Medicaid program. See 42 C.F.R. § 447.204 (1985); *Minnesota Assoc. of Health Care Facilities v. Minnesota Dept. of Public Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985) (providers are free to decline to participate in the Medicaid program if they are dissatisfied with a state's rates). Thus providers have the ability to opt out of the Medicaid program any time a state's rates are such that they believe it is not economically desirable to participate. Even so, as a condition to state participation, the Secretary requires each state to have in place an administrative appeals process through which providers may challenge reimbursement rates. 42 C.F.R. § 447.253(c) (1985). However, the Secretary, whose interpretation is entitled to "some deference," *Roanoke*, 479 U.S. 418, 427, expressly has rejected the call for private rights of action in the regulations adopted to implement the Boren Amendment on the ground that the statutes contained neither mandate nor authority to provide judicial recourse for

dissatisfied providers. 48 Fed. Reg. 56,052 (1983), see also Preamble to Final Rule, Medicaid Program; Payment for Long-Term Care Facilities and Inpatient Hospital Services, 48 Fed. Reg. 56,046 at 56,050 (1983).

B. The history of section 1396 supports a result directly contrary to that reached in the circuit court.

By the earlier reference to the increasing numbers of suits challenging state reimbursement rates, amici do not merely suggest the federal courts will be met with a flood of litigation, although those waters are unquestionably rising. The point, rather, is that year-by-year, provider-by-provider litigation over each aspect of each state's plan is becoming the rule, a reality manifestly inconsistent with Congress' unmistakable intent to reduce rather than increase federal oversight of the rate-making process. That intent is conspicuous in the legislative history of the 1980 amendments to the Medicaid statutes.

In 1980, in response to the "inherently inflationary" nature of the former "reasonable cost" standard, Congress enacted the Boren Amendment to the Medicaid statutes.[10] S. Rep. 96-471, 96th Cong., 1st Sess. 28-29.[11] The amendment "represented a significant change in the federal [reimbursement] standard," offering the states an opportunity to effect "more stringent cost containment" while freeing them from excessive "federal oversight of [their] reimbursement methodologies." *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d

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[10]Now embodied in 42 U.S.C. § 1396a(a)(13)(A) (1986).

[11]There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion of the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. See 126 Cong. Rec. 17,885-86 (1980). The Boren Amendment does not differ materially from the provision contained in the 1979 bill. See S.Rep. 96-471, *supra*, at 157-58. The text reported here is from the Senate report that accompanied the 1979 bill.

1226, 1228 (7th Cir. 1984). Congress chose to "give[ ] the States flexibility and discretion . . . to formulate their own methods and standards of payment." S. Rep. 96-471, at 28. By the same token, Congress intended "to reduce federal oversight of state reimbursement . . . ." *Mississippi Hosp. Ass'n., Inc. v. Heckler,* 701 F.2d 511, 521 (5th Cir. 1983). While pointing out that the Secretary would continue to insist on "assurances . . . that the payment rates . . . are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not overburden the States and facilities with marginal but massive paperwork requirements." S. Rep. 96-471, at 29. It is distinctly ironic that a Congressional effort to reduce cumbersome federal oversight of state programs and to contain Medicaid costs has become the impetus for a mounting tide of litigation and potential liability.

In the opinion below, the Fourth Circuit Court of Appeals acknowledged that, in *Pennhurst,* this Court left no doubt that Congressional intent is the "touchstone" of enforceable rights inquiry. The lower court's discussion of that intent, however, is largely limited to statements that merely reiterate the statutory references to "reasonable and adequate" rates. See 868 F.2d at 658-59. The court acknowledged that the purpose behind the Omnibus Budget Reconciliation Act (OBRA), of which the Boren Amendment was a part, was to reduce the federal budget. The court ignored, however, the parallel and equally important intent of the Boren Amendment to reduce federal oversight of state programs. Refusal to acknowledge this central goal of the Boren Amendment spared the court the unenviable task of reconciling the inevitably more intrusive effects of piecemeal litigation with Congress' indisputable intent to increase state autonomy in ratesetting.[12]

[12]Rather than having to defend its rates once, before a federal administrative agency, the states will now be forced to defend piecemeal as each disgruntled facility or band of facilities looks for the most sympathetic forum. For example, the Commonwealth of Pennsylvania is currently embroiled in six separate challenges. See Appendix A.

Based on its conclusion that Congress "intended no close scrutiny by the Secretary [of Health and Human Services]" of assurances by the states, the court below reasoned that the only way to effectuate the "guarantee" of reasonable and adequate rates is to allow providers to bring suit. 868 F.2d at 659. This deduction is based on a faulty reading of Congressional intent and an unjustified denigration of the role of the Secretary. The *exclusive* express enforcement mechanism of § 1396a(a)(13)(A) is the Secretary's authority to approve or disapprove state Medicaid plans. The previously discussed *Wehunt* and *West Allis* circuit court decisions apply this Court's *Cort v. Ash* decision to similar sections of the Social Security Act that were construed to be exclusively enforced by the government and held not to create enforceable rights by private parties. 875 F.2d 1558 (11th Cir. 1989); 852 F.2d 251 (7th Cir. 1988).

The circuit court correctly noted that Congress intended that state assurances would be considered satisfactory in the absence of a formal finding to the contrary by the Secretary. However, the court ignored the equally plain Congressional insistence on "proper accountability" to ensure that payment rates are, in fact, reasonably adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with minimal state and federal quality of care requirements and insure access to health care by Medicaid beneficiaries. See S. Rep. 96-471, at 29. The court's suggestion that Congress intended the Secretary to become a mere rubber stamp for whatever rates the states might conjure up is inconsistent not only with these expressions of Congressional intent, but also with the Secretary's view reflected in the regulations issued to implement the Boren Amendment,[13] and the

[13]See, e.g., Preamble to Interim Final Rule, Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964, 47,966 (1981). The regulations, as revised to meet the requirements of the 1980 amendments, require states to submit assurances at least annually and whenever they propose significantly to revise methods

(continued)

Secretary's actions in reviewing state plans. See, e.g., *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), *cert. denied*, 497 U.S. 1063 (1987) (discussing Secretary's disapproval of part of Nebraska's plan for 1983-84).

Congress intended to decrease, not increase, federal oversight of the rate-setting process. To that end Congress cut back federal administrative supervision to a level it deemed adequate to ensure proper accountability. The court of appeals has undone Congress' balance by layering judicial scrutiny onto administrative oversight. Supervision by litigation will almost inevitably entail greater delay and disruption in the administration of state Medicaid plans than would result from oversight by the Secretary even under the more demanding pre-Boren Amendment requirements. Further, it simply makes no sense to conclude that Congress intended to decrease federal oversight by the executive branch agency with the expertise in the operation of the Medicaid program and instead sought to give an increased role to the federal courts of the judicial branch for oversight of the state rate-setting process for healthcare providers. That result is manifestly inconsistent with Congress' intent and therefore erroneous.

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[13] *(continued)*
for determining payment rates. When amending plans or submitting new ones, states must submit related information on short-term effects and, to the extent feasible, long-term effects, on availability of care, type of care furnished, extent of provider participation and the degree to which costs are covered in hospitals serving a disproportionate number of low income patients. The Health Care Financing Administration "will review the information a State submits with respect to these items to determine whether it is reasonable to justify acceptance of the State's assurance." *Ibid.*

CONCLUSION

There is no valid public policy reason for health care providers, who are not the intended beneficiaries of the Act, to disrupt the Medicaid Program through § 1983 actions against state Medicaid agencies. To the contrary, 42 C.F.R. § 447.253 provides providers with a viable, efficient administrative remedy with subsequent state court judicial review to pursue their Medicaid rate disputes. Further, § 1396a(a)(13)(A) vests the Secretary with exclusive enforcement power over states' assurances concerning their state Medicaid plans. Failure to reverse the underlying circuit decision would disrupt this federal regulatory scheme and only delay if not divert the delivery of Medicaid tax dollars to the intended beneficiaries of the Medicaid Program.

For the reasons stated above, this Court should reverse the underlying circuit decision.

Respectfully submitted,

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No. 88-2043

In The
Supreme Court Of The United States

OCTOBER TERM, 1988

GERALD L. BALILES, ET AL.,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

APPENDIX TO BRIEF OF AMICI CURIAE

APPENDIX A

PENDING LITIGATION AT TIME OF PETITION FOR WRIT OF CERTIORARI

Colorado:

Amisub (PSL) Inc., State v. State of Colorado, Department of Social Services, No. 88-2482 — United States Court of Appeals for the Tenth Circuit

Delaware:

The Medical Center of Delaware, Inc. v. Eichler, No. 89-MY-9-1-CA — (petition for removal to United States District Court pending)

Georgia:

Health Facility Investments, Inc. dba Ansley Pavilion v. Johnson, No. 1:89CF844JOF — United States District Court, Northern District of Georgia

Hawaii:

Beverly Manor, Inc. v. Rubin, No. 85-0052 — United States District Court, District of Hawaii

Idaho:

Idaho Health Care Association, et al. v. Bowen, No. 88-1425 — United States District Court, District of Idaho

Jeff D., et al. v. Andrus, No. 87-3586 — United States Court of Appeals for the Ninth Circuit

Pope v. Donovan, No. 67738 — District Court of the State of Idaho

Illinois:

Chicago Osteopathic Medical Center, et al. v. Suter, No. 88C 1174 — United States District Court, Northern District of Illinois

Illinois Health Care Association, et al. v. Suter, No. 89C 849 — United States District Court, Northern District of Illinois

Michigan:

Health Care Association of Michigan, et al. v. Department of Social Services, et al., No. 89-50063 CA — United States District Court, Western District of Michigan

Minnesota:

REM-Bemidji, Inc., et al. v. Sandra S. Gardebring, Commissioner of the Minnesota Department of Human Services et al., No. 4-88-Civil-562 — United States District Court, District of Minnesota; dismissed without prejudice December 2, 1988, to permit completion of administrative challenge

Mississippi:

Mississippi Health Care Association v. J. Clinton Smith, No. JA 6-0765(B) — United States District Court, Southern District of Mississippi, Jackson Div. (consolidated with case below)

Independent Nursing Home Association v. J. Clinton Smith, No. JA 6-0731 (W) — (same court as above)

Missouri:

A.G.I.-Bluff Manor, Inc. v. Michael Reagen, Director, Missouri Department of Social Services et al., No. 85-4015-CV-CO5 — United States District Court, District of Missouri

Nevada:

Hillhaven, Inc., et al. v. State of Nevada Department of Human Resources, et al., No. CV 88-6222 — District Court of the State of Nevada, Washoe County

North Dakota:

North Dakota Hospital Association, et al. v. George A. Sinner, et al., Civ. No. A1-87-126 — United States District Court, Southwestern District of North Dakota

Ohio:

The Ohio Academy of Nursing Homes, Inc. v. Barry, et al., (88AP-826) — Court of Appeals of the State of Ohio (opinion June 22, 1989, certification to Ohio Supreme Court pending)

Oregon:

Oregon Association of Hospitals v. Department of Human Resources, (CF 88-225-DA) — United States District Court, District of Oregon

Volk et al. v. State, et al., No. A50092 — Oregon Court of Appeals

Francisco, et al. v. Department of Human Resources, et al., No. 89-6244 — United States District Court, District of Oregon

Pennsylvania:

West Virginia University Hospitals, Inc. v. Casey, 701 F.Supp. 496 (1988) under advisement on appeal to the United States Court of Appeals for the Third Circuit

Temple University v. White, et al., Civ. No. 88-6646 — Eastern District of Pennsylvania

Albert Einstein Medical Center, et al. v. White, et al., Civ. No. 88-8831 — same as above

Frankford Hospital v. Department of Public Welfare, et al., Civ. No. 88-8927 — same court

Hahnemann University Hospital, et al. v. Department of Public Welfare, et al., Civ. No. 88-9132 — same court

Hospital Association of Pennsylvania, et al. v. White, et al., Civ. No. 88-9849 — same court

South Carolina:

ANCO, Inc. et al v. State Health and Human Services Finance Commission, et al., No. ____ — on appeal to South Carolina Superior Court

Washington:

Folden et al. v. DSHS, No. C87-802TB — United States District Court, Western District of Washington

Multicare Medical Center, et al. v. State of Washington, et al., No. C88-421Z — same court

Wisconsin:

Beverely California Corporation v. Wisconsin Department of Health & Social Services, et al., No. 89-CV-2689 — Dane County Circuit Court

St. Michael Hospital of Franciscan Sisters of Milwaukee, Inc. v. Thompson, et al., No. 89-C-620C — United States District Court, Western District of Wisconsin